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ABSTRACT

A study was conducted to investigate the effects of teaching mental patients to use client-centered and experiential therapeutic skills with each other. To determine whether these skills could be learned, the 42 patients were pretested and posttested using the Hinterkopf-Brunswick Talker and Helper Rating Scales. The patients were randomly assigned to either an experimental or a control group. The results indicated that patients in the experimental group were successful in learning the majority of skills taught. Administration of the Discharge Readiness Inventory revealed significant improvement in experimental group subjects as compared to control group subjects on community adjustment potential, while no significant differences were found on other Discharge Readiness Inventory scales, such as psychosocial adequacy, belligerence, or manifest psychopathology. In addition to statistical results, patients reported other beneficial effects from the training. (Author)

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Teaching Mental Patients to Use Interpersonal Communication Skills with Each Other

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Teaching Mental Patients to Use Interpersonal Communication Skills with Each Other

It is widely acknowledged that mental patients have great difficulty with interpersonal communication, and that this difficulty is one of the main causes of the problems in their intrapsychic life (Sullivan, 1953). Research has shown that the quality of an individual's interpersonal relationships can be greatly enhanced by learning certain interpersonal communication skills which facilitate authenticity and empathy (Guerney, 1977). Therefore, it seems reasonable to teach mental patients interpersonal communication skills which promote authenticity and empathy.

The ability to be authentic involves the skill of verbalizing one's freshly felt thoughts and feelings. To help people do this, Gendlin (1969) has developed a method called experiential focusing. Hinterkopf revised and simplified the focusing instructions so they could be taught to chronic schizophrenics. Below, these revised experiential focusing skills are referred to as "talker skills" or "client skills."

The ability to communicate empathy is enhanced by training a person to say back another person's thoughts and feelings (Rogers, 1951). Hinterkopf (Hinterkopf and Brunswick, 1975) developed a system for teaching mental patients to use empathic listening skills with each other. Below, the revised empathic listening skills are referred to as "helper skills," "therapist skills," "client-centered reflecting," or "listening."

The purpose of this study was to determine whether eight training sessions in experiential focusing methods and client-centered reflecting methods would

result in: 1) patient improvement in essential talker skills, 2) patient improvement in essential helper skills, and 3) beneficial side-effects as measured by the Discharge Readiness Inventory. In order to test the first two hypotheses, it was necessary to measure helper skills and client skills. For this purpose the Talker and Helper Rating Scales were developed. Presented here is a description of the study and its results.

Method

Subjects

Subjects in the study were forty-two acute and chronic schizophrenic inpatients at Tinley Park Mental Health Center, Tinley Park, Illinois, including 23 females and 19 males, with an average age of 27.6. The subjects had an average of 4.57 previous admissions and an average of 17.2 weeks in the hospital this admission at the beginning of training. Only patients who could utter coherent sentences were selected for the study.

Experimental Design

The design utilized one experimental and one control group. The patients were pre- and posttested with the Talker and Helper Rating Scales. The Discharge Readiness Inventory was administered before and after the experiment to measure beneficial side effects. Systematic randomization was used to

assign subjects to either the experimental or the control group. The experimental group received training in using experiential focusing skills and client-centered reflecting skills with each other. Patients were trained in pairs, for eight sessions, each pair working with one trainer. The control group received an equal amount of attention in the form of recreation from the same trainers. Trainers were psychology and counseling students from surrounding colleges and universities.

Training Procedures[1]

The patients are gathered together and then paired. Each pair is joined by a trainer and goes off to practice, one patient being the talker and the other patient being the helper. Talkers and helpers exchange roles half-way through the session.

In order to teach client-talker skills, the trainer instructs the patient as follows:

> In order to solve your problems, we have found it helps to say three things while you're talking. I'd like you to say back these three things to me as I say them to you.
> 1) The first is to say how your body is feeling, for example, tense or relaxed. (The trainer asks the talker to reflect this.)
> 2) The second is to say your emotions, for example, sad, angry, or happy. (The trainer asks the talker to reflect this.)
> 3) The third is to say why you're having these emotions. For example, if you're sad, you might be sad because you got some bad news, or if you're happy, you might be happy because you got some good news. (The trainer asks the talker to reflect this.)

Then the trainer has the talker reflect all three things at one time, "body,

emotions, and why I'm having these emotions." The trainer then has the talker say how his body feels, what his emotions are, and why he is having these emotions at the present time. This is done to bring the patient's awareness into the here and now. The trainer teaches the talker to stay in touch with and verbalize these three aspects of awareness whenever he is talking about a problem. When the talker is talking about something that seems to lack personal relevance, such as the weather, the talker is asked if he is remembering to stay in touch with and say the three things. The talker is also instructed to correct the helper if what the helper reflected was not what the talker had meant.

At the beginning of each training session the trainer determines how much of the above the patient remembers and then reviews what the patient has forgotten. After the patient is able to remember the above three aspects without prompting, the trainer teaches him to say why he is having his bodily sensations. For example, if he feels tense it might be because he had his grounds pass taken away and couldn't leave the ward. The trainer neither encourages nor discourages hallucinations or delusions but continually instructs the helper to reflect them.

In order to teach helper skills,[2] the trainer explains:

> We want to teach you how to do something. We call it listening. It is a way of getting to know people and helping them. We want to teach it to you so that you can help each other. Whenever the talker says something about his problem, I want you to say it back in your own words. (If the helper could not say the meaning back accurately, we would have him say it back word-for-word.) If the talker has said as much as you can

> remember, I want you to tell him to stop, so you can say it back. We also want the rule that anything that is said here won't get told to someone outside.

When the helper becomes proficient at reflecting verbally expressed meaning and feeling, we add instructions to have the helper reflect any feelings he can infer from non-verbal behavior, such as voice tone, facial expression, and body posture, gesture, or movement. Patients are also taught to infer emotions by putting themselves in the talker's place.

Testing Procedures

The test measuring talker and helper skills was administered blind by an interviewer, and audiotapes of the test sessions were evaluated by two raters. Testing for the experimental and control groups involved a pretest and posttest. The pretest and the posttest each consisted of two subtests.

At the beginning of the first subtest one patient was designated the talker and one patient was designated the helper. The talker was given the following instructions:

Talker Instructions

> I would like you to pick a problem you have feelings about and talk about it. (If the patient answers that he has no problems, ask the patient how he feels about being in this hospital.)

The instructions given to the helper for the first subtest were as follows:

Helper General Instructions

> I want you to help the talker talk about his problem and let him know you understand.

After the patients had talked for several minutes, the patients were instructed to exchange talker and helper roles and were given the same talker and helper instructions again.

In the second subtest the same instructions were given to the talker as in the first subtest. However, the instructions given to the helper in the second subtest were as follows:

Helper Reflecting Instructions

> I want you to say back to the talker what he said to you. This will prove to the talker that you understand him.

Patients again exchanged talker and helper roles and were given the same talker and helper instructions.

In order to determine the effects of the first training session, the experimental group received a supplemental test using the Talker Instructions and the Helper Reflecting Instructions (see Table 1). The administration of the supplemental test was not considered to have an effect on the testing, since it was similar to instructions given in all training sessions.

Insert Table 1 about here

Measures

Talker and helper skills were measured by the Talker and Helper Rating Scales.[3] The rating scales were developed by the authors because no instruments were available to measure the skills at the level generally demonstrated by mental patients. Also, the authors wished to develop ratio scales, since only less powerful and less precise ordinal scales existed to measure these

skills. Two such ordinal scales are Gendlin's Experiencing Scale (Gendlin et al., 1968), which measures experiential focusing ability, and Carkhuff's Empathic Understanding Scale (Carkhuff, 1969).

Ratio measurement was accomplished by dividing the test into segments. A segment is defined as one statement or speaking turn of the talker and the subsequent utterance or silence of the helper. If a behavior occurs one or more times during a segment, that behavior is given a score of one for that segment. The total number of segments in which a behavior is displayed constitutes the behavior count. For every set of instructions (Talker and Helper Instructions) each patient was tested until there was a minimum of three segments or a maximum of six segments.

The Talker Rating Scale taps the patient's ability to use focusing skills. This scale measures the following client behaviors: 1) utterance of contents and 2) necessary talker interventions. Contents involves two subcategories: a) the utterance of talker material which provides the segment count and b) the utterance of affect and physical feeling words (such as "sad," "happy," "tense," or "relaxed"). Necessary talker interventions are counted when the talker corrects the helper if the helper's reflection is inaccurate.

The Helper Rating Scale measures the patient's ability to use reflecting skills. This scale measures the following helper behaviors: 1) the reflection of talker material, 2) necessary helper interventions, 3) nonreflective but useful or neutral responses, and 4) negative responses. Behaviors listed

under the first three categories are considered desirable; behaviors in the fourth category are considered undesirable.

Reflections include not only the reflection of verbal material (contents and feeling words), but also inferred affect, i.e., inferring affect from nonverbal communication, including voice tone, face, body posture, gesture and movement, and the talker's verbal contents. Necessary helper interventions are counted when the helper stops the talker before the talker says too much for the helper to remember. Nonreflective but useful or neutral responses are those that show interest but are nonevaluative and do not take the talker away from his process (verbalized feelings and what these feelings are about). This category includes nonevaluative interest (for example, "Yes," "Uh huh," or "That's interesting.") and the helper briefly answering the talker's question. Negative responses are those that take the talker away from his process and include mechanicalness, relevant responses, irrelevant responses, and silence. Mechanicalness is counted when the talker uses the first person, and the helper responds using the first or third person. For example, mechanicalness is counted if the talker says, "I feel sad.", and the helper responds saying, "I feel sad." or "He feels sad.", rather than saying, "You feel sad." Relevant responses are those that have a clear connection to the talker's subject matter, even though the helper may change the topic of conversation to himself. Relevant responses include relevant questions, such as, "When did this problem begin?"; relevant suggestions, such as,"Why don't you pray."; agreements, such as, "That's right."; and disagreements, for example, "You're mistaken." Irrelevant responses are those that have no clear connection to the talker's subject

matter, for example, if the talker is talking about his family, and the helper starts talking about a problem on the ward. Silence is marked only when the helper gives no verbal response during a given segment.

The Discharge Readiness Inventory (Hogarty and Ulrich, 1972) was administered to staff familiar with the patients but unaware as to whether patients were in the experimental or control group. It is a frequently used, standardized measure that provides an objective, quantified measure of the readiness of the schizophrenic patient for discharge. The test includes four scoring categories developed to reflect relatively independent aspects of the patient's readiness for discharge. These are: 1) Community Adjustment Potential, 2) Psychosocial Adequacy, 3) Belligerence, and 4) Manifest Psychopathology.

Factor 1, Community Adjustment Potential, is a 16-item measure of a patient's potential for posthospital adjustment in a number of important areas of social behavior and performance in the community. The authors of the Discharge Readiness Inventory have found that Community Adjustment Potential is the single most useful category in judging an individual patient's readiness for release. Factor 2, Psychosocial Adequacy, also 16-items, measures the actual performance of appropriate behavior in the hospital and adaptation to ward routines. Factor 3, Belligerence, is a six-item measure of obstreperous hospital behavior induced by little provocation. Factor 4, Manifest Psychopathology, is a three-item measure of hallucinatory and delusional behavior. High scores on Community Adjustment Potential and Psychosocial Adequacy are positive indicators of mental health or of a patient's assets. High scores on the other two scales represent illness.

Results

The results of the study fall into four categories: 1) interrater reliability of the Talker-Helper Rating Scales, 2) patient improvement on the Talker-Helper Rating Scales, 3) beneficial side-effects as measured by the Discharge Readiness Inventory, and 4) reports given by patients.

Interrater Reliability

Following the period during which the first author trained several students to score talker and helper behaviors, 36 of the 189 tapes completed by the subjects were randomly selected. The 36 tapes were scored independently by two raters. Each segment was scored on 12 subcategories, and the total number of agreements was divided by the total number of agreements plus disagreements. Percent agreements are shown on Table 2. The average percent of agreements for the Talker-Helper Rating Scales was 91%.

Insert Table 2 about here

Talker-Helper Rating Scales

Results on the Talker and Helper Rating Scales were compared between pretest 1 and posttest 1 and between pretest 2 and posttest 2 for the experimental and control groups, and between pretest 2 and the supplemental test for the experimental group (see Table 3).

Insert Table 3 about here

The subcategories or individual behaviors under nonreflective but useful or neutral responses and under negative responses were combined for statistical

analysis by adding all behavior counts within each category. This was appropriate, since none of the behaviors in either of these two categories were taught individually, as were behaviors in the other categories.

Since sessions varied in length (three to six segments), data was transformed into percentages instead of frequency counts. Percent occurrence was figured as the behavior count of a particular behavior divided by the total number of segments for that session.

A t-test between means of change scores for the experimental and control groups was performed on pre- and posttests 1 and on pre- and posttests 2. The experimental group made significantly greater gains on the Talker Rating Scale in feeling words between pre- and posttests 1 and between pre- and posttests 2. Significantly greater gains were made by the experimental group on the Helper Rating Scale in reflection of contents and feeling words and in the reduction of negative responses between pre- and posttests 1 and between pre- and posttests 2. A paired or correlated t-test was performed on the experimental group mean scores between pretest 2 and the supplemental test. Significant differences were found on the Helper Rating Scale in reflection of contents and feeling words, in nonreflective but useful or neutral responses, and in the reduction of negative responses.

Discharge Readiness Inventory

A gain score analysis of the results found on the Discharge Readiness Inventory revealed that 81% of the experimental group gained in Community Adjustment Potential from pre- to posttest, but only 38% of the control group

realized growth. The difference, 43%, is statistically significant ($p < .01$). No significant differences were found on the other three factors of the Discharge Readiness Inventory: Psychosocial Adequacy, Belligerence, and Manifest Psychopathology.

Patient Reports

In addition to statistical results, reports from patients point to the significance of teaching hospitalized schizophrenics to use counseling skills with each other. Patients reported benefits received from three aspects of the training: 1) receiving listening, 2) listening to another person, and 3) learning talker-focusing skills.

One benefit reported by patients from receiving listening was its improving interaction and communication with others. One patient said, "This listening brought out my social side. Each time I get listened to, I get less afraid of talking to people."

Feeling really heard was another benefit derived from receiving listening. Several patients compared receiving listening to the way staff generally responded to them on the ward. As one patient put it, "No one on the ward really listens to me about my problems, or when they do listen, they only hear about half of what I say. Getting things said back to me makes me feel a person has listened to me one hundred percent. It makes me feel the other person really cares about what I'm saying."

Several patients felt that receiving listening helped them in their problem solving. One patient said it helped keep her from acting out--something

for which she would lose her grounds pass. One day she said, "Before I came here, I felt like hitting the doctor. But just having expressed my anger and frustration has made me feel better. Now I don't feel I have to hit him."

Several patients with delusions or hallucinations said they were helped by being listened to. One patient said, "I have no one to talk to on the ward. If I talk to them about being the head of the C.I.A., they just put me down and punish me for it. So I've just stopped talking about it, even though it's still on my mind. But here in listening is the one place I can still talk about it."

Patients in mental hospitals are often reluctant to talk to staff about what they really feel because they are afraid it will lead to punishment or prevent their discharge. Our rule of confidentiality made patients more comfortable about revealing their thoughts and feelings. Several patients said they could confide things in listening that they could not confide on the ward. This benefit of confidentiality points to one possible advantage of using students and volunteers, rather than ward staff, as trainers.

A number of benefits of listening to another person were reported. Contrary to the commonly held belief that listening to other people's problems will overburden and harm patients, we have found that numerous benefits are derived from having patients listen to others. As one patient put it, "Realizing that I can help other people makes me feel better about myself. It even makes me feel important." Another patient said, "Listening to someone else's problems takes my mind off my own problems."

Listening training helped patients listen to others outside the training sessions. In addition to ~~observing~~ listening patients ~~listen~~ to each other on the ward, some patients reported improved relationships with family and friends from using listening skills during home visits. One patient said, "It helped me listen to my wife when I was on a home visit, and I've always had trouble doing that. It seemed to improve our relationship."

Seeing that other people had problems similar to their own helped patients not feel so bad about themselves for having problems. One patient said, "Seeing that other people had problems similar to my own makes me feel less guilty about my own problems. This makes my problems not seem so bad."

Also, listening to others often helped patients help themselves by learning to listen to themselves. Once the listening process became ingrained, the person could develop an internal listener. For example, one patient said, "I now try to listen to all my different parts, just like a good listener would." Thus, listening can lead to a problem-solving device that may be used even in the absence of a therapist or listener (Brunswick, Hinterkopf, and Burbridge, 1975).

Reports given by patients about learning talker-focusing skills included being able to communicate with others in a more meaningful manner. One patient reported, "Telling others my emotions and how my body feels makes communication with others feel close."

Patients also expressed excitement about experiencing new parts of themselves -- their bodies and their emotions. Several patients who started out not being able to feel their bodies learned to express in detail how different parts

of their bodies felt. Patients expressed this helped them feel more alive. One patient said, "It helps me get in touch with things that I didn't know I had inside me."

Another patient reported that it helped "slow his mind down." Focusing helped him with his problem of having too many things going on in his mind at one time--a problem frequently complained about by psychotics.

Other reports given by patients about learning focusing skills included having a better sense of direction in life about what they wanted. As one patient put it, "This focusing stuff sure helps me get in touch with my inner man. Before I used to be here, there and everywhere, according to what other people told me to do. Now I can know what I want to do and do it."

Discussion

Mental patients have been accustomed to receiving therapeutic care and direction from hospital personnel or staff. This study shows that mental patients can break out of this traditional role and become therapeutic helpers for others and learn to give themselves some therapeutic direction in the form of focusing. The study indicates that taking on these new roles results in beneficial side effects, especially in the area of Community Adjustment Potential.

The significant increase in talker feeling words for the experimental group between pre- and posttests 1 and between pre- and posttests 2 indicates that patients can learn to improve their client behavior.

The lack of significance in necessary talker interventions and necessary helper interventions was in part due to their infrequent use. Also, as the experimental group improved in reflecting abilities, there was less need for

their use. Because of the low frequency of behaviors in these two categories, their measurement might be unnecessary for research purposes. However, these two categories were useful to raters for determining segments.

The high significance of change in reflection of contents and feeling words between pre- and posttests 1 and between pre- and posttests 2 corresponds with our experience that basic reflecting is the skill taught most quickly and most easily. This is further supported by the percentage increase from pretest 2 to the supplemental test, which indicates that well over half of the learning of these two behaviors took place in the first training session. On the other hand, the nonsignificance of results in inferred affect implies that it is one of the most difficult skills to teach. Nonreflective but useful or neutral responses were nonsignificant between pre- and posttests 1 and between pre- and posttests 2 and significant in the wrong direction, i.e., a decrease, between pretest 2 and the supplemental test. These results are understandable, since these behaviors were counted only when no other responses were given. Thus, scores for these behaviors decreased as reflecting increased. The significant reduction in negative responses indicates that it is a behavior which can be extinguished. However, the data shows that this change is usually not accomplished quickly, i.e., within one training session. This is in contrast to the more quickly learned reflecting skills.

The findings from the Discharge Readiness Inventory indicate that teaching schizophrenics talker and helper skills leads to improvement in Community Adjustment Potential. The authors of the Discharge Readiness Inventory find this scale the most useful in judging an individual patient's readiness for release, since it measures improvement in essential skills necessary to function in society.

For example, this scale asks specific questions about autonomous behavior, ability to converse coherently and make visits outside the hospital, awareness of work world and community services, and adjustment with family and neighbors.

During the training of raters, the attempt to improve interrater reliability helped to refine and revise the Talker and Helper Rating Scales and make the instructions for raters more precise. For example, some behaviors such as voice tone and pitch were dropped, since it proved too difficult to rate reliably, and it was not a skill being taught. Affect and physical feeling words were combined into one subcategory, since the two frequently overlapped. Many rules were added to the rater instructions to make definitions more precise for rating.

Further research is needed in several areas. A study of longer duration could determine whether inferred affect could eventually be learned by a significant number of patients. A longitudinal study could investigate whether success in early training sessions is a predictor of later success. If predictions could be made, patients failing to learn basic skills in a certain number of training sessions could be dropped from training. On the other hand, failure to learn basic skills after a given number of training sessions could mean that it would be more beneficial to wait until these patients become "trainable," or it could mean that our training procedures for these patients need revision.

This type of research could also be attempted with other populations, such as outpatients and neurotics. These studies could investigate the time it takes different populations to learn the various skills and could also compare beneficial side effects.

Although bringing mental patients into more communication with each other by teaching them therapeutic skills is a valuable goal in itself, important questions still remain as to the long term benefits of such training. Follow-up studies to determine whether patients continue to use these skills on their own and whether beneficial side effects are lasting need to be done.

Teaching mental patients to use therapeutic skills with each other addresses a basic problem in many mental institutions. The shortage of staff in most of these mental health facilities makes it difficult to provide continued therapeutic attention to patients. Teaching patients counseling skills provides a unique approach to this problem in that it enables patients to provide therapeutic attention to each other.

References

Brunswick, L.K., Hinterkopf, E., and Burbridge, R. Cultivating positive empathic self-responding. Voices: The Art and Science of Psychotherapy, 1975, 11, 62-65.

Carkhuff, R.R. Helping and Human Relations: A Primer for Lay and Professional Helpers. Vol. I, New York: Holt, Rinehart and Winston, Inc., 1969.

Gendlin, E.T. Focusing. Psychotherapy: Theory, Research and Practice, 1969, 6, 4-15.

Gendlin, E.T. Client-centered and experiential psychotherapy. In: Innovations in Client-centered Therapy, Wexler, D.A. and Rice, L.N., Eds. New York: John Wiley and Sons, 1974, 211-246.

Gendlin, E.T., Beebe III, J., Cassens, J. et al. Focusing ability in psychotherapy, personality and creativity. Research in Psychotherapy, 1968, 3, 217-241.

Guerney, B.G. Relationship Enhancement. San Francisco: Jossey-Bass Publishers, 1977.

Hinterkopf, E. and Brunswick, L.K. Teaching therapeutic skills to mental patients. Psychotherapy: Theory, Research and Practice, 1975, 12, 8-12.

Hogarty, G.E. and Ulrich, R. The Discharge Readiness Inventory. Arch. Gen. Psychiat. 1972, 26, 419-426.

Orlando, N.J. The mental patient as therapeutic agent: self-change, power and caring. Psychotherapy: Theory, Research and Practice, 1974, 11, 58-62.

Rogers, C.R. Client-centered Therapy. Boston: Houghton Mifflin Company, 1951.

Rogers, C.R. On Becoming a Person. Boston: Houghton Mifflin Company, 1961.

Rogers, C.R. Empathic: an unappreciated way of being. The Counseling Psychologist, 1975, 12, 2-10.

Sullivan, H.S. The Interpersonal Theory of Psychiatry. New York: W. W. Norton & Company, Inc., 1953.

Truax, C.B. and Carkhuff, R.R. Toward Effective Counseling and Psychotherapy: Training and Practice. Chicago: Aldine Publishing Company, 1967.

Footnotes

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[1]For a further description of training procedures and methods for handling training problems, see Hinterkopf, E. and Brunswick, L. (1975).

[2]For another description of teaching patients reflecting skills, see Orlando (1974).

[3]The Hinterkopf-Brunswick Talker and Helper Rating Scales and Instructions are available from the first author upon request.

Table 1

The Schedule of Testing

	Before Any Sessions Pretest		After One Training Session	After Eight Sessions Posttest	
	Subtest 1	Subtest 2	Supplemental Test	Subtest 1	Subtest 2
Experimental Group	Talker Instructions	Talker Instructions	Talker Instructions	Talker Instructions	Talker Instructions
	Helper General Instructions	Helper Reflecting Instructions	Helper Reflecting Instructions	Helper General Instructions	Helper Reflecting Instructions
Control Group	Talker Instructions	Talker Instructions		Talker Instructions	Talker Instructions
	Helper General Instructions	Helper Reflecting Instructions		Helper General Instructions	Helper Reflecting Instructions

Table 2

Interrater Reliability in Scoring the Individual Subcategories Within the Talker and Helper Rating Scales

Subcategory	Percent Agreement
Talker Rating Scale:	
Feeling Words	.90
Talker Corrects Helper	.89
Helper Rating Scale:	
Reflects Contents	.89
Feeling Words	.90
Inferred Affect	.93
Helper Stops Talker	.93
Nonevaluative Interest	.88
Answers Question	.89
Mechanicalness	.95
Relevant Response	.89
Irrelevant Response	.90
Silence	.97

Table 3

Results of t-tests on Categories and Subcategories of the Talker and Helper Rating Scales

N=42 Categories and Subcategories	Experimental/Control Group Differences Pretest 1 to Posttest 1 (Helper General Instructions)		Experimental/ Control Group Differences Pretest 2 to Posttest 2 (Helper Reflecting Instructions)		Within Experimental Group Differences Pretest 2 to Supplemental Test (Helper Reflecting Instruction	
	Percentage Difference	t	Percentage Difference	t	Percentage Difference	t
Talker Rating Scale:						
Contents:						
Feeling Words	21.6	2.49*	26.2	2.88**	12.7	1.62
Necessary Talker Interventions:	3.9	0.32	1.2	0.64	-1.5	-0.33
Helper Rating Scale:						
Reflections:						
Contents	90.3	25.93**	39.8	2.77**	36.1	4.19**
Feeling Words	88.1	12.47**	44.7	2.51**	50.0	4.18**
Inferred Affect	6.1	1.21	4.5	0.31	1.8	0.34
Necessary Helper Interventions:	2.8	0.27	3.8	0.35	3.1	0.71
Nonreflective but Useful or Neutral Responses:	-16.7	-1.69	-6.5	-0.65	-14.6	-2.50*
Negative Responses:	-84.6	-8.39**	-80.3	-5.69**	-38.9	-3.21**

* $p < .05$

** $p < .01$